MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Wol+Med, Edward Wolski, M.D. 2436 I-35 East, South, Ste. 336 Denton, TX 76205	MDR Tracking No.: M4-04-2468-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Insurance Co. 2875 Browns Bridge Rd. Gainesville, GA 30504 Box 28	Date of Injury: Employer's Name: Covenant Group Holdings, Inc. Insurance Carrier's No.: 973397425

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/15/03	**01/15/03**	**64999**	**$154.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated November 6, 2003 states in part, "…For date of service 1/15/3, CPT code 64999, the carrier denied the charges using PEC-F. We feel they used the incorrect PEC because this particular CPT code does not have a MAR. We feel they violated Rule 133.304… For the same date of service and CPT code, 1/15/3, CPT 64999, the carrier failed to respond to our request for reconsideration. WE feel they have failed to comply with Rule 133.304 Request for Reconsideration…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summer dated December 3, 2003 states in part, "…The provider is using code 64999 to bill for a 'paravertebral regional nerve block' which is the use of the MATRIX electroceutical system. After significant research into the details of this procedure, it has been determined that this treatment is actually electrical stimulation. It uses a different wide-band frequency and more intense current output than other stimulation equipment but still is a form of electrical stimulation. The manufacturer of the equipment states that administration does not require an MD but can be done by a trained physical therapist… Code 64999 is for an unlisted procedure and is reimbursed according to the documentation submitted for the code. Upon review, it was determined that code 64550, application of surface (transcutaneious) neurostimulator, is the code which most nearly describes the treatment rendered and reimbursement is being made based upon the MAR for that code which is $101.00…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 94999 for date of service 01/15/03. PEC – F was used; however, this particular code according to the 1996 MFG is a DOP code and does not have a MAR value. The insurance carrier has reimbursed the treatment at another billing code's value without contacting the sender of the bill and is in violation of Rule 133.301(b). However, per Rule 133.1(a)(8)(B) the health care provider has not supported the amount billed to be their usual reimbursement for this CPT Code; therefore, additional reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

	Marguerite Foster	02/17/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____